STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011129	A. BUILDING: _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE HOME HEALTH INDIANAPOLIS	5354 W 62ND ST INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This survey was a State relicensure survey. The survey was extended. Survey dates: February 17, 18, 19, 23, and 24, 2016 Facility ID#: 011129 Provider #: 157582 Census: 80	N 000		
N 470	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. This RULE is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure services had been provided in accordance with its own infection control policies and procedures and the Center for Disease control "Standard Precautions" in 1 of 6 home visit observations. (# 3) Findings include: 1. A policy titled "Hand Hygiene" revised 12/2012, indicated " ... 3. Hand decontamination using an alcohol - based hand gel should e performed: A. Before having direct contact with patients. B. Before accessing theclean area of the visit bag. C. Before donning sterile gloves when perfomring sterile procedures; befrore inserting indwelling urinary catheters, peripheral	N 470		

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N 470	Continued From page 1 vascular catheters, or other invasive devices. D. After contact with a patient's intact skin (when taking a pulse, blood pressure or lifting a patient. E. After contact with body fluids or excretions, mucous membranes, non - intact skin, and wound dressings, if hands are not visibly contaminated. F. When moving from a contaminated body site to a clean body site during patient care. G. After contact with inanimate objects, including medical equipment, in the immediate vicinity of the patient. H. After removing gloves. I. After completing care, prior to leaving the patient's home .... " 2. A policy titled "Contaminated Materials Disposition" revised 12/2012, indicated " ... 3. Equipment: A. Cleaning reusable equipment that may come in contact with mucous membranes or body fluids: [This refers to equipment that personnel transports from patient to patient in the performance of their duties, i.e., BP [blood pressure] cuffs, stethoscope, thermometers, scales ....]" 1. wipe exposed portions of equipment with alcohol or other appropriate cleaning solution .... " 3. A policy titled "Contaminated Waste Disposition" revised 12/2012, indicated " ... 3. COntaminated paper wastes [disposable floves, gowns, masks, paper towels, tubings dressings, etc.], should be placed in a plastic puncture resistant bag and secured. It should be double bagged and, in possible, placed in a plastic trash container with tight lid and labeled as appropriate .... " 4. The Centers for Disease Control Standard Precautions indicated, "IV. Standard Precautions ... IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary	N 470		

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N 470	Continued From page 2 touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces ... Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves ... IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently ... IV.B. Personal protective equipment (PPE) ... IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin ... could occur. " 5. A home visit was made to patient number 3, with Employee C, a registered nurse, on 02/18/16 at 10:30 AM. Employee B, was observed providing wound care to the patient's left heel. The patient's primary diagnosis was necrotizing fascities [flesh eating disorder]. Employee B was observed to clean hands and applied gloves, remove the patient's sock and stocking, cut the patient's kerlix wrap and removed a soiled dressing. Without changing gloves, the employee	N 470		

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N 470	Continued From page 3 B continued to clean the patient's wound, applied solosite wound gel around the patient's wound. Continuing to not change his / her gloves, Employee B removed and cut a piece of medicated dressing with the same scissors that was used to to remove the kerlix without cleaning to prior use. Employee B proceeded to apply the medicated dressing, 4 x 4, foam dressing, then wrapped the foot with kerlix. At this time, Employee B removed his / her gloves and cleaned hands with hand gel. Employee B cleaned the patient area of soiled dressings with his / her bare hands and carried it to the patient's kitchen and placed the soiled items in the trash can. Employee B cleaned her hands and applied gloves, obtained a blood sample from the patient's finger, removed the strip that contained the patient's blood, put the hand held machine in his / her traveling bag without cleaning. 6. Employee C, Registered Nurse, was interviewed after the home visit on 02/18/16. Employee C was unable to identify his / her error with infection control.	N 470		
N 484	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. This RULE is not met as evidenced by: Based on interview and record review, the agency	N 484		

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N 484	Continued From page 4 failed to ensure their efforts were coordinated effectively and documented with all disciplines providing service to patients coordinated effectively and documented for 3 of 9 patients receiving therapy services in a sample of 12. (# 7, 8, and 9) Findings include: 1. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively. b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively. 2. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts	N 484		

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N 484	Continued From page 5 were coordinated effectively. b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively. 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The occupational therapist failed to ensure his / her efforts were coordinated effectively. b. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The physical therapist failed to ensure his / her efforts were coordinated effectively. 5. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see. 6. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case	N 484		

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N 484	Continued From page 6 conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided .... " 7. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences .... "	N 484		
N 486	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. This RULE is not met as evidenced by: Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services for 2 of 2 records reviewed (# 2 and 11) of patients receiving outside services in a sample of 12. Findings include: 1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had a plan of care established by a physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit	N 486		

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N 486	Continued From page 7 the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center. 2. Clinical record number 11, SOC 10/18/15, included a plan of care established by the physician for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center. 3. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic." 4. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided .... " 5. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences .... "	N 486		

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N 504	Continued From page 8	N 504		
N 504	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that patients were informed in advance of the disciplines that will furnish care, type of care to be provided, and the frequency of the proposed visits for 6 of 12 records reviewed (# 1, 3, 6, 7, 11, and 12) Findings include: 1. Clinical record number 1, SOC (start of care) 05/15/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section failed to evidence a frequency for skilled nursing. 2. Clinical record number 3, SOC 01/18/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/18/16. The "Consent For Treatment" section indicated skilled nursing, home health aide, physical therapy and occupational therapy was to be provided. The	N 504		

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N 504	Continued From page 9 frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse and home health aide. 3. Clinical record number 6, SOC 02/17/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 02/17/16. The "Consent For Treatment" section indicated skilled nursing, physical therapy and occupational therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse. 4. Clinical record number 7, SOC 01/27/16, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 01/27/16. The "Consent For Treatment" section indicated skilled nursing two times a week for six weeks, physical therapy and occupational therapy two times a week for six weeks. a. The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the home health aide. b. Review of the OASIS comprehensive admission assessment dated 01/27/16, the narrative note indicated the patient refused skilled nursing services. The admitting clinician also failed to change the frequency proposed to a one time visit on the Admission Consent Service Agreement.	N 504		

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N 504	Continued From page 10 c. Review of the physical therapy initial evaluation visit note dated 01/27/16, the physical therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. d. Review of the occupational therapy initial evaluation visit note dated 02/03/16, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. 5. Clinical record number 11, SOC 10/18/15, had an established plan of care by a physician for the certificating period 10/18/15 to 12/16/15, with orders for skilled nursing, physical and occupational therapy services. The "Consent for Treatment" section failed to include physical an occupational therapy services. The admitting clinician failed to inform the patient / representative in advance about the proposed physical and occupational therapy services. 6. Clinical record number 12, SOC 11/10/15, had an "Admission Consent Service Agreement" signed and dated by the patient and agency representative on 11/10/15. The "Consent For Treatment" section indicated skilled nursing, physical therapy, occupational therapy, and speech therapy was to be provided. The frequency indicated "eval [evaluate] and treat." The admitting clinician failed to inform the patient / representative in advance about the frequency of the visits proposed to be furnished by the skilled nurse. a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the	N 504		

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N 504	Continued From page 11 occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. b. Review of the speech therapy initial evaluation visit note dated 11/13/15, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. 7. The Administrator was unable to provide any additional documentation and/or information when asked on 2/19/16 at 2:50 PM.	N 504		
N 522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed (# 3), failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed (# 3); skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed (# 8, 9, 10); occupational and physical therapy follow the therapy frequency in the plan of care for 2 of 9 records reviewed (# 9, 11), failed to obtain PT/INR as ordered in the plan of care for 1 of 2	N 522		

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N 522	Continued From page 12 records reviewed of patients with PT/INR orders (# 9), and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds. (#10) Findings include: 1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16. a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants. b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency. c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan	N 522		

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N 522	Continued From page 13 of care failed to be specific in the acceptance of physician orders. 2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week. a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care. b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care. 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy two times a week for four weeks starting week starting 01/17/16. a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled	N 522		

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N 522	Continued From page 14 nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care. b. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The occupational therapist failed to follow the plan of care. c. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care. 4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing. a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care. b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow	N 522		

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N 522	Continued From page 15 the plan of care. 5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for physical therapy one time a week for one week and occupational therapy one time a week for one week. Physical and Occupation therapy failed to follow the plan of care. 6. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 7. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes .... "	N 522		
N 524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required.	N 524		

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N 524	Continued From page 16 (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11) Findings include: 1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis,	N 524		

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N 524	Continued From page 17 patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. The OASIS dated 02/13/16, states in a narrative, "Patient has renal failure and has dialysis on Monday Wednesday and Friday." The Plan of Care (POC) failed to indicate that the patient was receiving dialysis treatments. b. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient stated that she was on a 1500 calorie diet with fluid restrictions. The plan of care (POC) indicated that the patient was on a regular diet. c. A physician order dated 1/26, 2/2, and 2/16/16 from the wound clinic and a physician order from a coagulation clinic dated 2/5/16 were reviewed. The plan of care failed to be updated to include acceptance of physician orders from the outside clinics / facilities 2. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16. a. Section 14 of the DME (durable medical equipment) and supplies portion of the plan of care, indicated the patient was being supplied foam dressings. The clinical record failed to evidence a wound or skin condition warranting the need for foam dressings. The agency failed to update and revise the plan of care. b. After a home visit with the patient on 02/18/16, the patient's clinical record with the Assisted Living Facility was reviewed. An order dated 08/07/16, indicated the patient's Atorvastatin had been discontinued. Section 10 of the medication section continued to indicate	N 524		

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N 524	Continued From page 18	N 524		

the patient was taking Atorvastatin 10 milligrams daily. The plan of care failed to be revised and updated to reflect the patient's current medication list.

3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16.

1. Section 10 of the medication portion of the plan of care indicated the patient was taking Creon [medication for pancreatitis] 24,000 - 76,000 - 120,000 units, 2 tabs 3 times a day, Saccharomyces Boulardii oral, 250 mg [milligrams] 1 tab daily, acetaminophen 325 mg every 6 hours as needed for pain. Section 17 of the allergy portion indicated the patient was allergic to neomycin sulfate and niaspan.

2. A hospital discharge summary dated 12/29/15, indicated the patient discharged home with Creon 24,000 3 tabs 3 times a day, no saccharomyces was listed on the discharged list of medications, and acetaminophen 2 - 500 mg tabs every 6 hours three times a day. The summary also indicated the patient was allergic to not only neomycin sulfate and niaspan, but also to neomycin otic and neosporin.

3. During a home visit with the patient on 02/18/16 at 10:30 a.m., the patient stated he / she was not familiar nor did he / she know what saccharomyces medication was. The plan of care failed to be updated and revised to include all allergies and correct medications with accurate dosages and frequency.

4. Clinical record number 5, SOC 02/01/16, included an established plan of care by a physician for the certification period of 02/01/16 to

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N 524	Continued From page 19 03/31/16. a. Review of the discharge paperwork from a skilled nursing facility dated 01/14/16, indicated the patient was allergic to Albuterol, Lexapro, and Duricef. b. Section 17 of the Allergy section of the plan of care indicated the patient was only allergic to Duricef. The plan of care failed to include allergies to Albuterol and Lexapro. 5. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16, with orders for skilled nursing, physical, and occupational therapy. a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has a history of congestive heart failure and atrial fibrillation. a. The cardiovascular assessment indicated the patient's had a trace of edema to the bilateral lower extremities. In reviewing the plan of care, the Registered failed to include interventions such as obtaining / assessing the patient's weight at each visit, when to notify the physician for increase in weight due to fluid retention, and educate the patient on sodium restrictions / diet and measurable goals. b. The Registered Nurse also had indicated the patient was not taking an anticoagulant. In reviewing of the plan of care and medication	N 524		

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profile, the patient was taking Xarelto (anticoagulant medication) 15 mg (milligrams) daily. The plan of care failed to include interventions such as education, assessment, and safety measures and measurable goals.

c. M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low risk of developing pressure ulcers. The plan of care failed to include interventions to prevent skin breakdown and measurable goals.

d. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The plan of care failed to include the cite of the skin lesion being treated, failed to include the interventions for the skin lesion and measurable goals.

6. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16.

a. Review of the OASIS comprehensive admission assessment dated 01/27/16, line M1730 asked if the patient had been screened for depression, using a standardized validated depression screening tool. The answer provided

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N 524	Continued From page 21 indicated "yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression." The plan of care failed to be revised and updated to include interventions and goals for depression. 7. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing 2 times a week for 5 weeks to " ... perform / teach wound care to the patient and caregiver, wound vac to RLE diabetic .... " The plan of care failed to include the type of foam dressing to be used, draping, and the suction settings for the wound vac to be used upon admission. a. Review of the patient's most recent Podiatry visit note dated 10/13/15, included, but not limited to the following medications: Combigan 0.2 - 0.5 % 45 grams APP AA solution twice a day; Glucosamine - Chondroitin 500 400 mg two tablets twice a day; Nitro Bid 2% apply 1" twice a day, Imdur ER 60 mg daily, and a Multivitamin daily. Section 10 of the plan of care failed to evidence the prescribed medications listed. b. The podiatry visit note dated 10/13/15, also indicated the patient was taking Lopressor 50 mg, 1/2 tab twice a day, Vitamin D3 daily, and Vitamin E 200 U, 2 capsules daily. Section 10 of the plan of care indicated the patient was taking 50 mg of Lopressor twice a day, Vitamin D2 & K - Berberine - Hops orally 500 units - 500 mcg (micrograms) - 90 mg - 370 mg daily, and Vitamin E - Vitamin C - Magnesium - Zinc oral 100 Units - 100 mg - 10 mg - 18 mg. The medications on the plan of care failed to provide	N 524		

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N 524	Continued From page 22 accurate medications and their dosage. 8. The agency policy and procedure for contents of clinical record (Policy No. HH:2-055.1; revised December, 2012) states as follows: "A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel." The procedure related to said policy indicates that "[r]elevant diet or dietary restrictions, in any" be included in the clinical record for skilled patients. 9. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 10. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes .... "	N 524		
N 532	410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any,	N 532		

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N 532	Continued From page 23 of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure primary care physicians are notified within a timely manner of missed visits in 2 of 12 records reviewed (# 9 and 11) and failed to notify the physician of a patient's significant weight loss in 1 of 12 record reviewed. (# 9) Findings include: 1. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. a. The plan of care indicated the frequency for occupational therapy was two times a week for four weeks starting week starting 01/17/16. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits. b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss. 2. Clinical record number 11, SOC (start of care) 10/18/15, with an established plan of care for the certification period of 10/18/15 to 12/16/15, with	N 532		

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N 532	Continued From page 24 orders for skilled nursing two times a week for five weeks, physical therapy one time a week for one week, and occupational therapy one time a week for one week. a. Review of the "Visits to Orders Comparison Report", the skilled nurse had attempted to schedule visits on 10/20 (patient hospitalized), 10/24 (patient / caregiver refused), 10/28 (patient / caregiver refused), 10/30 (scheduling error), and 11/03/15 (patient declined skilled nursing service). The only visit made was the admission assessment on 10/18/15. b. A "Client Coordination Note Report" dated 10/28/15, indicated care was projected to continue, but the patient had been refusing visits. The note indicated the case manager was to follow up with primary care physician. c. A "Client Coordination Note Report" dated 11/05,15, indicated that the primary care physician was notified of the patient's refusal and was being discharged from services. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits. 3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 4. A policy titled "Nutrtional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect	N 532		

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N 532	Continued From page 25 the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult .... " 5. A policy titled "Assessing Patient's Response / Reporting To Physician" dated 12/2012, indicated " ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient .... "	N 532		
N 537	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to ensure the plan of care include initial and ongoing wound treatments with interventions and goals for 1 of 12 records reviewed (# 3); failed to ensure the plan of care included names of physicians that the clinicians can accept orders from for 1 of 12 records reviewed (# 3); skilled nurses follow the nursing frequency in the plan of care for 3 of 9 records reviewed (# 8, 9, 10); failed to obtain PT/INR as ordered in the plan of care for 1 of 2 records reviewed of patients with PT/INR orders (# 9); and failed to follow wound treatment orders for 1 of 5 records reviewed of patients with wounds. (#10) Findings include: 1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to	N 537		

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N 537	Continued From page 26 03/17/16. a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants. b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency. c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02, and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders. 2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week.	N 537		

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N 537	Continued From page 27 a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care. b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care. 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks. a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care. b. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care.	N 537		

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N 537	Continued From page 28 4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing. a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care. b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care. 5. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 6. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes .... "	N 537		

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N 541	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to assess patient wounds within a timely manner and per agency policy for 4 of 5 records reviewed of patients with wounds in a sample of 12. (# 3, 8, 9 and 10) Findings include: 1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16. a. A physician order from the wound clinic dated 02/02/16, indicated for skilled nursing to provide wound treatment to the bilateral lower extremities daily for 2 weeks. b. Review of the skilled nursing visit notes, the clinical record evidenced a LPN (Licensed Practical Nurse) made daily visits to the patient between 02/04/16 to 02/15/16. The last assessment by registered nurse was made on 1/27/16. The registered nurse failed to reassess the patient's wounds between 01/27/16 to 02/15/16. 2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to	N 541		

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N 541	Continued From page 30 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week. a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing wound to the left lower leg. A skilled nursing visit note dated 12/14/15, indicated the patient requested Employee L, a Registered Nurse / Wound Nurse, assess her wound. Employee L did not see the patient until 12/21/15. Between 12/10/15 to 12/21/15, the patient developed three areas, two partial thickness wounds to the mid - pretibial lower leg and one to the left lateral ankle. The registered nurse failed to follow up and assess the patient's left lower leg wounds within a timely manner. b. A skilled nursing visit note dated 12/28/16, indicated the patient's had two left partial thickness wound to the mid - pretibial lower leg and a trauma wound to the left lateral ankle. The wounds were measured during this time. c. A skilled nursing visit note dated 01/04/16, indicated the registered nurse provided treatment to the three wounds, but failed to evidence that the wounds had not been measured. d. A skilled nursing visit note dated 01/07/16, indicated skilled nursing was going to continue with visits and was not discharging at the present time due to a wound that was not completely healed. The visit note failed to evidence that the wounds had not been measured. e. Review of the skilled nursing visit notes, the clinical record failed to evidence a visit by the registered nurse for reassessment of the wounds between 01/10/16 to 01/16/16.	N 541		

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N 541	Continued From page 31 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16, with orders for skilled nursing. a. A physician order dated 01/20/16, indicated the skilled nurse was to perform wound treatments to an unknown area. b. Review of skilled nursing visit notes dated 02/08/16 and 02/11/16, indicated the registered nurse performed treatment to the right anterior mid pretibial area. The visits notes failed to evidence measurements of the wound for both nursing visit. The clinical record failed to evidenced wound measurements between 02/07/16 to 02/15/16. 4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period of 02/09/16 to 04/04/16, with orders for skilled nursing to perform / teach decubitus care to the left upper buttock. a. Review of the skilled nursing visits, the clinical record evidenced a LPN made visits twice a week between 02/09/16 and 2/19/16. The registered nurse failed to reassess the patient's wound between 02/09/16 to 02/19/16. 5. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 541		
N 542	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services	N 542		

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N 542	Continued From page 32	N 542		

are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:
(C) Initiate the plan of care and necessary revisions.

This RULE is not met as evidenced by:
Based on record review and interview, the Registered Nurse failed to update and revise the plan of care to include all medications taken by the patient, wound care supplies, allergies, interventions and measurable goals, and outside services being provided for 7 of 12 records reviewed. (# 1, 2, 3, 5, 6, 7, and 11)

Findings include:

1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had an established plan of care signed by the physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks.

a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. The OASIS dated 02/13/16, states in a narrative, "Patient has renal failure and has dialysis on Monday Wednesday and Friday." The Plan of Care (POC) failed to indicate that the patient was receiving dialysis treatments.

b. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit

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N 542	Continued From page 33 the patient stated that she was on a 1500 calorie diet with fluid restrictions. The plan of care (POC) indicated that the patient was on a regular diet. c. A physician order dated 1/26, 2/2, and 2/16/16 from the wound clinic and a physician order from a coagulation clinic dated 2/5/16 were reviewed. The plan of care failed to be updated to include acceptance of physician orders from the outside clinics / facilities. 2. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16. a. Section 14 of the DME (durable medical equipment) and supplies portion of the plan of care, indicated the patient was being supplied foam dressings. The clinical record failed to evidence a wound or skin condition warranting the need for foam dressings. The agency failed to update and revise the plan of care. b. After a home visit with the patient on 02/18/16, the patient's clinical record with the Assisted Living Facility was reviewed. An order dated 08/07/16, indicated the patient's Atorvastatin had been discontinued. Section 10 of the medication section continued to indicate the patient was taking Atorvastatin 10 milligrams daily. The plan of care failed to be revised and updated to reflect the patient's current medication list. 3. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification period of 01/18/16 to 03/17/16. 1. Section 10 of the medication portion of the	N 542		

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N 542	Continued From page 34 plan of care indicated the patient was taking Creon [medication for pancreatitis] 24,000 - 76,000 - 120,000 units, 2 tabs 3 times a day, Saccharomyces Boulardii oral, 250 mg [milligrams] 1 tab daily, acetaminophen 325 mg every 6 hours as needed for pain. Section 17 of the allergy portion indicated the patient was allergic to neomycin sulfate and niaspan. 2. A hospital discharge summary dated 12/29/15, indicated the patient discharged home with Creon 24,000 3 tabs 3 times a day, no saccharomyces was listed on the discharged list of medications, and acetaminophen 2 - 500 mg tabs every 6 hours three times a day. The summary also indicated the patient was allergic to not only neomycin sulfate and niaspan, but also to neomycin otic and neosporin. 3. During a home visit with the patient on 02/18/16 at 10:30 a.m., the patient stated he / she was not familiar nor did he / she know what saccharomyces medication was. The plan of care failed to be updated and revised to include all allergies and correct medications with accurate dosages and frequency. 4. Clinical record number 5, SOC 02/01/16, included an established plan of care by a physician for the certification period of 02/01/16 to 03/31/16. a. Review of the discharge paperwork from a skilled nursing facility dated 01/14/16, indicated the patient was allergic to Albuterol, Lexapro, and Duricef. b. Section 17 of the Allergy section of the plan of care indicated the patient was only allergic to Duricef. The plan of care failed to include	N 542		

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N 542	Continued From page 35 allergies to Albuterol and Lexapro. 5. Clinical record number 6, SOC 02/08/16, included a plan of care established by a physician for the certification periods of 02/08/16 to 04/07/16, with orders for skilled nursing, physical, and occupational therapy. a. Review of the OASIS comprehensive admission assessment dated 02/08/16, the Registered Nurse indicated the main focus of the patient's care, was to assess / evaluate cardiovascular and respiratory status, monitor daily weights, edema, and shortness of breath due to the patient has a history of congestive heart failure and atrial fibrillation. a. The cardiovascular assessment indicated the patient's had a trace of edema to the bilateral lower extremities. In reviewing the plan of care, the Registered failed to include interventions such as obtaining / assessing the patient's weight at each visit, when to notify the physician for increase in weight due to fluid retention, and educate the patient on sodium restrictions / diet and measurable goals. b. The Registered Nurse also had indicated the patient was not taking an anticoagulant. In reviewing of the plan of care and medication profile, the patient was taking Xarelto (anticoagulant medication) 15 mg (milligrams) daily. The plan of care failed to include interventions such as education, assessment, and safety measures and measurable goals. c. M1302 asked if the patient was at risk for developing pressure ulcers. The answer provided was "no." M2250 asked if the physician ordered plan of care include interventions to	N 542		

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prevent pressure ulcers. The answer provided was "NA [not applicable] Pressure ulcer risk assessment [clinical or formal] indicates patient is not at risk of developing pressure ulcers." The Braden scale indicated the patient scored a 16, which indicated the patient is at a low risk of developing pressure ulcers. The plan of care failed to include interventions to prevent skin breakdown and measurable goals.

d. M1350 asked if the patient had a skin lesion or open wound that was receiving interventions by the agency. The OASIS assessment was reviewed by quality assurance nurse within the office and the question was changed from "no" to "yes". The admitting nurse agreed to the change of answers. The plan of care failed to include the cite of the skin lesion being treated, failed to include the interventions for the skin lesion and measurable goals.

6. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16.

a. Review of the OASIS comprehensive admission assessment dated 01/27/16, line M1730 asked if the patient had been screened for depression, using a standardized validated depression screening tool. The answer provided indicated "yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression." The plan of care failed to be revised and updated to include interventions and goals for depression.

7. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15,

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N 542	Continued From page 37 with orders for skilled nursing 2 times a week for 5 weeks to " ... perform / teach wound care to the patient and caregiver, wound vac to RLE diabetic .... " The plan of care failed to include the type of foam dressing to be used, draping, and the suction settings for the wound vac to be used upon admission. a. Review of the patient's most recent Podiatry visit note dated 10/13/15, included, but not limited to the following medications: Combigan 0.2 - 0.5 % 45 grams APP AA solution twice a day; Glucosamine - Chondroitin 500 400 mg two tablets twice a day; Nitro Bid 2% apply 1" twice a day, Imdur ER 60 mg daily, and a Multivitamin daily. Section 10 of the plan of care failed to evidence the prescribed medications listed. b. The podiatry visit note dated 10/13/15, also indicated the patient was taking Lopressor 50 mg, 1/2 tab twice a day, Vitamin D3 daily, and Vitamin E 200 U, 2 capsules daily. Section 10 of the plan of care indicated the patient was taking 50 mg of Lopressor twice a day, Vitamin D2 & K - Berberine - Hops orally 500 units - 500 mcg (micrograms) - 90 mg - 370 mg daily, and Vitamin E - Vitamin C - Magnesium - Zinc oral 100 Units - 100 mg - 10 mg - 18 mg. The medications on the plan of care failed to provide accurate medications and their dosage. 8. The agency policy and procedure for contents of clinical record (Policy No. HH:2-055.1; revised December, 2012) states as follows: "A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and	N 542		

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N 542	Continued From page 38 results in detail, and facilitate continuity of care among organization and contract personnel." The procedure related to said policy indicates that "[r]elevant diet or dietary restrictions, in any" be included in the clinical record for skilled patients. 9. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 10. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes .... " 11. A policy titled "Care Planning Process" dated 12/2012, indicated " ... The clinical plan of care include ... Food or drug allergies ... goals / outcomes to be achieved ... medications and treatments ... supplies and equipment required ... Frequency and duration of visits ... Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing assessments, and analysis of patient response to care against goals and outcomes .... "	N 542		
N 543	410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of	N 543		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 543	Continued From page 39 practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on record review and interview, the Registered Nurse failed to address / consult with a dietician in regards to a patient's significant weight loss for 1 of 1 record reviewed of a patient with weight loss in a sample of 12. (# 9) Findings include: 1. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. Patient diagnoses include but not limited to, heart failure, atrial fibrillation, diabetes mellitus II, and chronic kidney disease stage five. a. A skilled nursing visit note dated 01/22/16, indicated the patient had a weight of 197 pounds.. b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss. 2. The Administrator was unable to provide any additional documentation and/or information when asked on 2/19/16 at 2:50 PM. 3. A policy titled "Nutrtional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ...	N 543		

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	011129	A. BUILDING: _____ B. WING _____	02/24/2016

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N 543	Continued From page 40 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult .... "	N 543		
N 545	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. This RULE is not met as evidenced by: Based on interview and record review, the agency failed to ensure their efforts were coordinated effectively and documented with the dialysis centers that was furnishing services for 2 of 2 records reviewed (# 2 and 11) of patients receiving outside services, and failed to ensure all disciplines providing service to patients coordinated effectively for 3 of 9 patients receiving therapy services in a sample of 12. (# 7, 8, and 9) Findings include: 1. The clinical record for patient number 2 was reviewed on 02/18/16 at 10:30 AM. The clinical record had a plan of care established by a physician for certification periods of 02/13/16 to 04/12/16, with orders for skilled nursing one day a week for one week, two days a week for 3 weeks, and 1 day a week for two weeks. a. A home visit for patient number 2 occurred on 02/18/16 at 9:30 AM. During the home visit the patient was observed to have a dialysis fistula on the her left forearm. When questioned as to	N 545		

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N 545	Continued From page 41 whether she was currently receiving dialysis, patient number 2 stated that she received dialysis on Monday, Wednesday, and Friday. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center. 2. Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager. 3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The	N 545		

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N 545	Continued From page 42 clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager. 4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. a. A skilled nursing visit note dated 01/29/16, indicated that the RN obtained a verbal order from the physician office to repeat an INR on 2/2/16. b. A skilled nursing visit note dated 02/04/16, indicated that the LPN obtained a PT/INR from the patient. The clinical record failed to evidence written documentation of the coordination of services related to correct date of the lab specimen to be obtained. c. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager. d. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the	N 545		

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N 545	Continued From page 43 occupational therapist and skilled nursing. The agency failed to ensure efforts were coordinated effectively. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. 5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15. The plan of care diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis. Review of the care coordination notes, the agency failed to evidence coordination of care between the agency and the dialysis center. 6. An interview with the Administrator on 02/18/16 at 2:25 PM, stated that the agency does "not typically keep records from dialysis care, or communicate directly with the dialysis clinic." 7. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see. 8. A policy titled "Continuity of Care" dated 12/2012, indicated " ... Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes ... F. Coummunicating between multiple disciplines to optimize visit schedules for the benefit of the patient and the care to be provided .... " 9. A policy titled "Case Conference / Progress Summary" dated 02/2012, indicated " ... Case	N 545		

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N 545	Continued From page 44 conferences will include utilization review; therefore, all clinicians - both direct and contract personnel 0 working with patients will participate iin case conferences .... "	N 545		
N 546	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure primary care physicians are notified within a timely manner of missed visits in 2 of 12 records reviewed (# 9 and 11) and failed to notify the physician of a patient's significant weight loss in 1 of 12 record reviewed. (# 9) Findings include: 1. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16. a. The plan of care indicated the frequency for occupational therapy was two times a week for four weeks starting week starting 01/17/16. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16.	N 546		

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N 546	Continued From page 45 The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits. b. A skilled nursing visit note dated 01/29/16, indicated the patient had a 20 pound weight loss since his / her hospitalization. The clinical record failed to indicate if the physician had been notified of the significant weight loss. 2. Clinical record number 11, SOC (start of care) 10/18/15, with an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for skilled nursing two times a week for five weeks, physical therapy one time a week for one week, and occupational therapy one time a week for one week. a. Review of the "Visits to Orders Comparison Report", the skilled nurse had attempted to schedule visits on 10/20 (patient hospitalized), 10/24 (patient / caregiver refused), 10/28 (patient / caregiver refused), 10/30 (scheduling error), and 11/03/15 (patient declined skilled nursing service). The only visit made was the admission assessment on 10/18/15. b. A "Client Coordination Note Report" dated 10/28/15, indicated care was projected to continue, but the patient had been refusing visits. The note indicated the case manager was to follow up with primary care physician. c. A "Client Coordination Note Report" dated 11/05,15, indicated that the primary care physician was notified of the patient's refusal and was being discharged from services. The clinical record failed to evidence that the physician had been notified in a timely manner of the missed visits.	N 546		

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N 546	Continued From page 46 3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 4. A policy titled "Nutrtional Assessment" dated 12/2012, indicated " ... When the initial and comprehensive assessment indicates an alteration in nutritional status, the clinician will make a referral to a qualified health care professional for further nutritional assessment ... 3. Documentation in the clinical record will reflect the physician (or other authorized licensed independent practitioner) contact and the order for a nutritional consult .... " 5. A policy titled "Assessing Patient's Response / Reporting To Physician" dated 12/2012, indicated " ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient .... "	N 546		
N 547	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure orders provided by outside facilities were clarified and had all pertinent and specific information including route, rate, and strength within the order for 1 of 1	N 547		

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N 547	Continued From page 47	N 547		

patient record reviewed with Intravenous fluids (#12); failed to include include if a PT/INR was to be obtained peripherally or by finger stick for 1 of 2 patient records reviewed getting PT/INRs (#9); failed to include all locations of wounds in a physician's order for 1 of 5 records reviewed (# 9) of patient's with wounds, and failed to write an order for speech therapy for 1 of 2 patient's receiving speech therapy (# 9) in a sample of 12 patient records.

Findings include:

1. Clinical record number 9, SOC (start of care) 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16.

a. A physician's order dated 01/20/16, indicated for the skilled nurse to "remove old dressing, cleanse wound with normal saline, pat dry, cover with foam dressings." The physicians order failed to include location of the wound.

b. A skilled nursing visit note dated 01/29/16, indicated in the narrative note "Repeat INR next Tuesday 2/2/16." The verbal order failed to be put into writing, signed, and dated by the skilled nurse.

c. A physician order dated 02/09/16, indicated for a skilled nurse to obtain a PT/INR on 02/23/16. The order failed to include if the PT/INR was to be obtained by peripheral stick or by finger stick.

d. Review of the therapy visit notes, the clinical record evidence speech therapy visits dated 01/25, 01/27, 02/03, and 02/08/16. The clinical record failed to evidence an order for

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N 547	Continued From page 48 speech therapy. 2. Clinical record number 12, SOC 11/10/15, included an established plan of care for the certification periods of 11/10/15 to 01/08/16. a. A physician order dated 11/19/15, indicated "HH [home health] nurse to administer 500 ml [milliliters] NS [normal saline] now, then repeat tomorrow." The order was taken by the residential living nurse. The agency failed to have the ordered clarified to include the strength of the normal saline, rate of infusion, and if the patient needed a peripheral IV started for infusion or if the patient already had an implanted port / central line for route. 3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 4. A policy titled "Intravenous Administration of Medications / Solutions" dated 12/2012, indicated " ... All orders for IV medications and solutions will specify medication name and dosage, diluent type and amount, route, frequency of administration, and rate of infusion ... IV medications and solutions will only be administered through a peripheral or central venous line .... "	N 547		
N 550	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed	N 550		

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N 550	Continued From page 49 practical nurses and other individuals as appropriate. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the home health aide written instructions were accurate in relation to the patient's performance abilities. (#3) Findings include: 1. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living. a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks. b. During a home visit on 02/16/16 at 10:30 AM, the patient verbalized that he / she had his / her first bath in 6 months recently. The patient verbalized he / she had been afraid to get into the shower due to his illness, weakness, and unsteady gait. The patient indicated he / she had been getting sponge bathes at the sink. The home health aide written care instructions failed to be specific to the patient needs. 2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 550		

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N 553	410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the LPN [Licensed Practical Nurse] followed the agency administrative policy / job description in regards to communicating with the RN [registered nurse] and / or Director of Professional Services and the physician in relation to a patient developing integumentary changes to his / her lower extremity for 1 of 5 records reviewed with a patient receiving services from a LPN. (# 8) Finding include: 1. A job description for an LPN dated 12/2012, indicated " ... Essential functions ... 3. Performs an ongoing assessment during each visit and documents data inpatient medical records. Communicates significant findings, problems, or changes in the patient's condition to the supervising RN and / or Director of Professional Services and the physician and documents all findings, communications and appropriate interventions. Documents nursing interventions including patient response .... " 2. Clinical record number 8, SOC (start of care) 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16. a. A skilled nursing visit note dated 12/10/15,	N 553		

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N 553	Continued From page 51 indicated the patient had a weeping / oozing area on LLE [left lower extremity] anterior lower half was noted. SN [skilled nurse] offered to interfere and help in taking care of that wound but the pt [patient] refused completely and stated that his / her dermatologist said that this is contact dermatitis and it will heal by self." The clinical record failed to evidence that the LPN notified the RN / Director of Professional Services. 3. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 4. A policy titled "Scope of Service" dated 12/2012, indicated " ... 2. Licensed practical / vacation nurses supplement the nursing care needs of the patient as provided by the registered nurse. These include ... Providing services in accordance with organization policies ... Preparing clinical and progress notes ... Assisting the registered nurse or physician in performing specialized procedures and duties ... Assisting the registered nurse in carrying out the plan of care .... "	N 553		
N 555	410 IAC 17-14-1(a)(2)(C) Scope of Services Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures. This RULE is not met as evidenced by: Based on record review and interview, the LPN (Licensed Practical Nurse) failed to include a description of wounds being observed and failed	N 555		

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N 555	Continued From page 52 to document treatments that were being provided in accordance to physician orders in 3 of 5 records reviewed of patients with wounds. (# 3, 8, and 10) Finding include: 1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16, with orders for skilled nursing 2 times a week for 6 weeks. a. A physician order from the wound clinic dated 01/26/16, indicated three ulcer areas to be treated. 1. An ulcer to the right anterior leg measuring 3.5 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times a week for 1 week. 2. An ulcer to the left heel measuring 1.8 cm x 1.3 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with plain water and moisturize the heels and legs, apply a nickel thick layer of Santyl [debrding agent] to the wound, followed by 4 x 4 gauze, foam heel, hydrogel, kerlix, and paper tape daily for 1 week. 3. An ulcer to the right 2nd toe measuring 1.7 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 1 week. 1. A skilled nursing visit note dated 01/28/16, indicated the LPN provided wound care to the bilateral lower extremity wounds under aseptic technique per orders. The skilled nursing assessment failed to evidence the specific location (left heels, right anterior leg, and right 2nd digit toe), assessment, and treatment	N 555		

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N 555	Continued From page 53	N 555		

provided to the bilateral extremity wounds.

2. A skilled nursing visit note dated 01/30/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

3.. A skilled nursing visit note dated 01/31/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

4. A skilled nursing visit note dated 02/01/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

b. A physician order from the wound clinic dated 02/02/16, indicated the right anterior leg ulcer measured 3 cm x 1 cm x 0.1 cm. The treatment included to cleanse the per i- ulcer area with sterile water and moisturize the dry skin 3 times a week for 1 week. The order also indicated an ulcer to the left heel measuring 1.5 cm x 0.8 cm x 0.1 cm. The treatment included to cleanse the peri - ulcer area with sterile water and moisturize the heels and legs, apply PRISMA [medicated dressing], followed by 4 x 4 gauze, foam heel, kerlix and tape daily for two weeks. The right 2nd digit toe ulcer measured 0.8 cm x 0.6 cm x 0.1 cm. The treatment included to

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cleanse the wound with plain water. Use vicks vapor rub as the primary dressing, place a pad between left 3rd and 4th toes, daily for 2 weeks.

1. A skilled nursing visit note dated 02/04/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

2. A skilled nursing visit note dated 02/05/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

3. A skilled nursing visit note dated 02/06/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

4. A skilled nursing visit note dated 02/07/16, indicated the LPN performed wound care to the bilateral lower extremities. The LPN provided an assessment to the left heel. The LPN failed to evidence specific locations of wounds and their assessment (right anterior leg and right 2nd digit toe).

5. A skilled nursing visit note dated 02/08/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds

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and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.

6. A skilled nursing visit note dated 02/09/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.

7. A skilled nursing visit note dated 02/10/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.

8. A skilled nursing visit note dated 02/11/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.

9. A skilled nursing visit note dated 02/12/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe.

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N 555	Continued From page 56 10. A skilled nursing visit note dated 02/13/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe. 11. A skilled nursing visit note dated 02/14/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe. 12. A skilled nursing visit note dated 02/15/16, the narrative note indicated the LPN performed wound care to the left heel only, but yet the treatment portion evidenced all wounds and their treatment. The LPN provided an assessment to the left heel. The LPN failed to evidence an assessment to the right anterior leg and right 2nd digit toe. 2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week. a. A skilled nursing visit note dated 12/10/15, indicated the patient had a weeping / oozing area on LLE [left lower extremity] anterior lower half was noted. A skilled nursing visit note dated 12/14/15, indicated the patient had a wound, but	N 555		

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N 555	Continued From page 57 failed to evidence an assessment of the wound. 3. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing. a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care. b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19/16, the wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care. 4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 555		
N 560	410 IAC 17-14-1(b) Scope of Services Rule 14 Sec. 1(b) Any therapy services furnished by the home health agency shall be provided by: (1) a physical therapist or physical therapist assistant supervised by a licensed physical therapist in accordance with IC 25-27-1; or (2) an occupational therapist or occupational therapist assistant supervised by an occupational therapist in accordance with IC 25-23.5.	N 560		

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N 560	Continued From page 58 (3) a speech-language pathologist or audiologist in accordance with IC 25-35.6. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the occupational and physical therapy follow the therapy frequency in the plan of care for 5 of 9 records reviewed in a sample of 12. (# 3, 8, 9, 10, and 11) Findings include: 1. Clinical record number 3, SOC 01/18/16, included a plan of care established by a physician for the certification periods of 01/18/16 to 03/17/16. a. Review of the OASIS comprehensive admission assessment dated 01/18/16, the primary diagnosis indicated the patient had necrotizing faciitis. Other diagnoses included atrial fibrillation, coronary heart disease, restless leg syndrome, chronic pancreatitis, and long term use of anticoagulants. b. A wound assessment indicated the patient had a stage II pressure ulcer to the left heel that measured 2 x 1.3 x 0.1 cm [centimeters]. The wound was described as partial thickness wound. The note indicated the skilled nurse provided treatment to the left heel which included cleaning the site with plain water, applied moisturizer the heel and legs, applied 4 x 4 gauze, foam heel, wrapped with kerlix, and secured with paper tape. The plan of care failed to include the admitting and ongoing treatment, as well as interventions and goals that were to be provided by the agency. c. The clinical record evidence physician orders from the wound clinic dated 01/27, 02/02,	N 560		

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N 560	Continued From page 59 and 02/16/16, and orders from a physician at the coagulation clinic dated 02/05/16. Section 21 of the plan of care indicated the home health agency "may accept orders from the following physicians: All treating and consulting." The plan of care failed to be specific in the acceptance of physician orders. 2. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16, with orders for skilled nursing one time a week for one week, two times a week for 2 weeks, then one time a week for one week. a. Review of the skilled nursing visit notes, the skilled nurse failed to make a second visit to the patient during week two (11/22/15 to 11/28/15). During week five, the skilled nurse made a visit without a physician's order. The skilled nurse failed to follow the plan of care. b. A physician's order dated 12/20/15, indicated a new skilled nursing frequency of one time a week for one week then one time a week every other week times 2. During the week of 12/27/15 to 01/02/16, the skilled nurse made two visits and during the week of 01/03/16 to 01/09/16, the skilled nurse made one extra visit to the patient without a physician's order. The skilled nurse failed to follow the plan of care. 3. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for skilled nursing one time a week for one week then two times a week for six weeks and occupational therapy two times a week for four weeks starting week starting 01/17/16.	N 560		

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N 560	Continued From page 60 a. A physician's order dated 01/20/16, indicated effective 01/24/16, the skilled nurse was to see the patient two times a week for one week, three times a week for two weeks, then two times a week for one week. Review of the skilled nursing visit notes indicated the skilled nurse made an extra nursing visit (total of three visits) during the week of 2/24/16 and failed to make a third nursing visit during the week of 02/07/16. The skilled nurse failed to follow the plan of care. b. Review of the occupational therapy visit notes, indicated the occupational therapist failed to make a second visit during the week of 01/21/16. The occupational therapist failed to follow the plan of care. c. A physician's order dated 02/09/16, indicated for skilled nursing to recheck the PT/INR on 02/23/16. The clinical record evidenced the skilled nurse made a visit on 2/18/16, and obtained the PT/INR. The skilled nurse failed to follow the plan of care. 4. Clinical record number 10, SOC 12/10/15, included a plan of care established by a physician for the certification period 02/09/16 to 04/04/16, with order for skilled nursing one time a week for one week, two times a week for three weeks, then one time a week for two weeks to perform and teach decubitus care to left upper buttock, cleanse with normal saline, pate dry, cover with foam dressing. a. Review of the skilled nursing visits, a LPN made a visit on 2/9/16 and 2/12/16. The skilled nurse failed to follow the plan of care. b. Review of the skilled nursing visits on 2/09, 02/12, 02/16, 02/19, and 02/23/16, the	N 560		

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N 560	Continued From page 61 wound care section indicated, "wound care provided ... decubitus care to L [left] buttock cleanse with normal saline, pat dry, apply nonsting skin barrier to surrounding tissue, cover with duoderm. The skilled nurse failed to follow the plan of care. 5. Clinical record number 11, SOC (start of care) 10/18/15, included an established plan of care for the certification period of 10/18/15 to 12/16/15, with orders for physical therapy one time a week for one week and occupational therapy one time a week for one week. Physical and Occupation therapy failed to follow the plan of care. 6. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 560		
N 563	410 IAC 17-14-1(c)(2) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months; This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the registered nurse performed a comprehensive assessment for recertification in the last 5 days of the 60 day certification period for 1 of 2 patient record reviewed who was recertified for an additional 60 days. (# 8) Finding include:	N 563		

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N 563	Continued From page 62 1. Clinical record number 8, SOC [start of care] 11/18/15, included a plan of care established by a physician for the certification period 11/18/15 to 01/16/16. a. The clinical record evidenced a comprehensive reassessment dated 01/21/16. The skilled nurse failed to complete the comprehensive assessment for recertification between the dates of 01/12/16 to 01/16/16. 2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM. 3. A policy titled "Initial and Comprehensive Assessment" dated 12/2012, indicated "A comprehensive patient assessment will be completed ... The last five (5) days of every 60 - day episode beginning with the start of care date (recertification) .... " 4. A policy titled "Reassessments / Recertification" dated 12/2012, indicated " ... The comprehensive assessment must be updated and revised every 60 days from the start of care ... OASIS assessments within the mandated time frames: A. recertification day 56 - 60 of the current certification period ... 2. For each new episode of care, a comprehensive assessment will be completed no earlier than five (5) days before and no later than one (1) day before the calendar day on which the new episode of care will begin .... "	N 563		
N 565	410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist	N 565		

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N 565	Continued From page 63 listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); This RULE is not met as evidenced by: Based on record review and interview, the therapist failed to include frequency of proposed visits with speech, physical, and occupational therapy and if the patient / representative was in agreement with the plan of care in 3 of 9 records reviewed of patients receiving therapy in a sample of 12. (# 8, 9, and 12) Findings include: 1. Clinical record number 8, SOC (start of care) 11/18/15, included a plan of care established by a physician for the certification period of 11/18/15 to 01/16/16, with orders for physical and occupational therapy services. a. Review of the physical therapy initial evaluation visit dated 11/18/15, the physical therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. b. Review of the occupational therapy initial evaluation visit dated 11/23/15, the occupational assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. 2. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period 01/14/16 to 03/13/16, with orders for physical and occupational therapy services.	N 565		

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N 565	Continued From page 64 a. Review of the occupational therapy initial evaluation visit dated 01/18/16, failed to include the frequency of the proposed visits. b. Review of the physical therapy initial evaluation visit dated 01/19/16, failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. 3. Clinical record number 12, SOC 11/10/15, included a plan of care established by a physician for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services. a. Review of the occupational therapy initial evaluation visit note dated 11/13/15, the occupational therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. b. Review of the speech therapy initial evaluation visit note dated 11/13/15, the speech therapy assessment plan failed to include the frequency of the proposed visits and failed to include if the patient / representative was in agreement with the plan of care. 4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 565		
N 566	410 IAC 17-14-1(c)(5) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist	N 566		

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N 566	Continued From page 65 listed in subsection (b) of this rule shall: (5) prepare clinical notes; This RULE is not met as evidenced by: Based on record review and interview, Occupational and Speech therapy failed to ensure that a discharge summary had been completed at the end of services that were provide for 1 of 4 records reviewed of patient with discharged therapy services in a sample of 12. (# 12) Findings include: 1. Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services. a. Review of the occupational therapy visit notes, the occupational therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary. b. Review of the speech therapy visit notes the speech therapist last visit was made on 12/01/15. The speech therapist failed to complete a discharge summary. 2. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 566		
N 567	410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:	N 567		

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N 567	Continued From page 66 (6) advise and consult with the family and other home health agency personnel; This RULE is not met as evidenced by: Based on record review and interview, the Occupational and Physical therapist failed to ensure to coordinate with other therapists and case managers and document their efforts for 3 of 9 patients receiving multiple (therapy) services in a sample of 12. (# 7, 8, and 9) Findings include: Clinical record number 7, SOC 01/27/16, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16, with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the physical therapy initial evaluation visit dated 01/27/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. b. Review of the occupational therapy initial evaluation visit dated 02/03/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager. 3. Clinical record number 8, SOC 11/28/15, included a plan of care established by a physician for the certification period of 11/28/15 to 01/26/16, with orders for skilled nursing, physical therapy,	N 567		

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N 567	Continued From page 67 and occupational therapy. a. Review of the physical therapy initial evaluation visit dated 11/18/15, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. b. Review of the occupational therapy initial evaluation visit dated 11/23/15, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the occupational therapist documented his / her coordination efforts with the physical therapist and with the case manager. 4. Clinical record number 9, SOC 01/14/16, included a plan of care established by a physician for the certification period of 01/14/16 to 03/13/16 with orders for skilled nursing, physical therapy, and occupational therapy. a. Review of the occupational therapy initial evaluation visit dated 01/18/16, indicated there was no coordination of services with physical therapy and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination efforts with the occupational therapist and with the case manager. b. Review of the physical therapy initial evaluation visit dated 01/19/16, indicated there was no coordination of services with the occupational therapist and skilled nursing. The clinical record failed to evidence that the physical therapist documented his / her coordination	N 567		

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N 567	Continued From page 68 efforts with the occupational therapist and with the case manager. 5. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated therapy would "typically" coordinate with the team members and put a note in the care coordination area in the computer for everyone to see.	N 567		
N 570	410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may: (1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate. This RULE is not met as evidenced by: Based on record review and interview, the Physical Therapist and Occupational Therapist failed to provide supervision of the physical therapy assistance according to Article 6 and certified occupational therapy assistant according to Article 10 for 1 of 1 patient who had therapy assistants in a sample of 12. (# 7) Findings include: 1. Article 6. Physical Therapists and Physical Therapists' Assistants, 844 IAC (Indiana Administrative Code) 6 - 1 - 2 Definitions indicated " ... [g] ... With respect to the supervision of physical therapist's assistants under IC [Indiana Code] 25 - 27 - 1 - 2 [c], unless the supervising physical therapist or physician is on the premises to provide constant supervision,	N 570		

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N 570	Continued From page 69 the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments ... [3] A consultation between a supervising physical therapist or a physician and the physical therapist's assistant may be in person, by telephone, or by a telecommunications device for the deaf [TDD], so long as there is interactive communication concerning patient care .... " 2. Article 10. Occupational Therapists and Occupational Therapy Assistants, 844 IAC 10 - 5 - 6 Documentation Sec. 6 indicated "Thee occupational therapist shall countersign within seven [7] calendar days all documentation written by the occupational therapy assistant, which will become part of the patient's permanent record." 3. Clinical record number 7, SOC 01/27/16 (start of care), included a plan of care established by the physician for the certification period of 01/27/16 to 03/26/16, with orders for physical therapy one time a week for one week then two times a week for six weeks, and occupational therapy one time a week for one week then two times a week for five weeks. a. Review of supervisory visit report completed by a registered nurse on 02/09 and 02/23/16, asked for the name of therapist being evaluated. The registered nurse indicated Employee A, PT [physical therapist] Employee F, OT [occupational therapist], Employee G, COTA [certified occupational therapy assistant], Employee K, PT, and Employee H, PTA [physical therapy assistant]. b. Review of the physical therapy assistant	N 570		

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N 570	Continued From page 70 notes dated 02/05, 02/17, and 02/19/16, the visit note and the clinical record failed to evidence that the physical therapist and the physical therapy assistant communicated with each other after the visit was. c. Review of the certified occupational therapy assistant note dated 02/12/16, the visit note and clinical record failed to evidence co-signature / communication between the occupational therapist and the certified occupational therapy assistant. 4. Employee M, a PT and Therapy Service Manager on 2/24/16 at 12:00 PM. Employee M stated physical / occupational therapist and physical therapy assistants / certified occupational therapy assistants would email and / or text each other if there was a need but was not aware of the of the daily communication to be documented between PT and PTA, as well as weekly signatures between OT and COTA. 5. The Administrator and Director of Clinical Services was interviewed on 2/24/16 at 2:00 PM. The Administrator and Director of Clinical Services stated PT / OT only supervises the PTA / COTA.	N 570		
N 608	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.	N 608		

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N 608	Continued From page 71 (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure that clinical visit notes were truthful and accurate for 2 of 12 records reviewed (# 1 and 3), failed to ensure the clinical record include discharge summaries from speech and occupational therapy for 1 of 9 record reviewed of patients receiving therapy. (# 12) Findings include: 1. Clinical record number 1, SOC 05/15/15 (start of care), included a plan of care established by a physician for the certification period of 01/10/16 to 03/09/16. The patient has a known history of a sacral debubitous ulcer that was treated by the agency in September, 2015. a. A home visit was made with the LPN (licensed practical nurse) on 02/18/16 at 8:15 a.m. The LPN was observed to calibrate the patient's glucometer, obtain blood sugar, inject insulin, obtained vital signs, and ask generalized assessments. The LPN did not assess the patient's skin in the coccyx area. The skilled nursing visit note indicated the LPN had performed a skin assessment. The LPN inaccurately documented an assessment that was not performed.	N 608		

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N 608	Continued From page 72 2. Clinical record number 3, SOC (start of care) 01/18/16, included a plan of care established by the physician for the certification period of 01/18/16 to 03/17/16, with orders for home health aide services to provide assistance with personal care and activities of daily living. a. A home health aide written plan of instructions dated 01/18/16, indicated for the home health aide to provide a shower, shampoo, and skin care one time a week for 5 weeks. b. Review of the home health aide visit notes, that are being performed by a licensed practical nurse, indicated the patient had received a shower on 01/28, 02/02, 02/09, 02/16/16. c. During a home visit on 02/16/16 at 10:30 AM, the patient verbalized that he / she had his / her first bath in 6 months recently. The patient verbalized he / she had been afraid to get into the shower due to his illness, weakness, and unsteady gait. The patient indicated he / she had been getting sponge bathes at the sink. The LPN acting as a home health aide inaccurately documented the bathing task that was not performed. 3. Clinical record number 12, SOC (start of care) 11/10/15, included an established plan of care for the certification period of 11/10/15 to 01/08/16, with orders for occupational and speech therapy services. a. Review of the occupational therapy visit notes, the occupational therapist last visit was made on 12/03/15. The occupational therapist failed to complete a discharge summary. b. Review of the speech therapy visit notes	N 608		

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N 608	Continued From page 73 the speech therapist last visit was made on 12/01/15. The speech therapist failed to complete a discharge summary. 4. The Administrator and Director of Clinical Services was unable to provide any additional documentation and/or information when asked on 2/24/16 at 2:20 PM.	N 608		